

BREASTFEEDING PEER COUNSELOR CONTACT LOG

Mother's name: _____ Mother's ID Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Breastfed ever? _____ Due date: ____/____/____

Baby's date of birth: ____/____/____ Baby's name: _____

Baby's birth wt. _____ Discharge wt. _____ Two week wt. _____

Type of contact: 1=phone 2=home visit 3=group class 4=mail 5=clinic visit 6=hospital visit 7=other

Prenatal Contacts

	1	2	3	4	5	6	7
Date							
Type of Contact							
Content (check areas discussed)							
Breastfeeding barriers							
Breastfeeding benefits							
Basic breastfeeding technique							
Breastfeeding management							
Return to work or school							
Class or group invitation							
WIC Referral							

Postpartum Contacts

	1	2	3	4	5	6	7
Date							
Type of Contact							
Content (check areas discussed)							
Baby's bowel movements							
Baby fussy/colicky							
Baby sick							
Breastfeeding barriers							
Basic breastfeeding technique (position/latch)							
Breast infection							
Class or group invitation							
Engorgement							

Type of contact: 1=phone 2=home visit 3=group class 4=mail 5=clinic visit 6=hospital visit 7=other

Postpartum Contacts	1	2	3	4	5	6	7
Growth Spurt							
Let-down reflex							
Milk Supply Issues							
Medical situation/medication use							
Nursing schedule							
Premature infant							
Pumping/hand expression							
Relactation							
Return to work or school							
Sore nipples							
Teething							
Weaning							
WIC referral							

Date	Narrative Documentation of Contacts

Age weaned from breast: _____ Reason: _____

Breastfeeding Counselor Signature: _____ Date: _____